Form HC-61
(Rev. 08/00)

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
830 Punchbowl Street
P.O. Box 3769
Honolulu, Hawaii 96812-3769

HEALTH CARE (HC)
APPLICATION FOR SELF-INSURANCE AUTHORIZATION

To the Director of the Department of Labor and Industrial Relations:

The undersigned, an employer, hereby makes application for permission to operate as a self-insurer pursuant to Chapter 393, Hawaii Revised Statutes, as amended, and in support of such application provides the following information:

1. Name of applicant: _____ DOL No.: _____
(If a corporation, show name exactly as it is in the chapter or articles of incorporation.)

Please check: _____ Corporation _____ Sole Proprietorship
_____ Partnership _____ Other

2. (a) Mailing address in Hawaii: _____
_____
(b) Street address in Hawaii (if different from above): _____
_____
(c) Telephone No. in Hawaii: _____
(d) Facsimile No.: _____

3. Location of other business places in Hawaii: _____
_____

4. Nature of business: _____

5. (a) Number of employees **in Hawaii** to be covered under HC plan: _____
(b) Number of employees in Hawaii and out of state that are covered under the self-insured HC plan (to include parent and subsidiary companies): _____

6. If a subsidiary company:
(a) Name of parent company: _____
(b) Address: _____
(c) Parent company's percentage of stock ownership: _____

7. Will any of applicant's operations be conducted under a name other than that shown in item 1 or item 6.(a)? _____ If yes,
(a) Name: _____
(b) Address: _____
(c) Nature of business: _____

8. Date of commencement of business in Hawaii: _____

9. Enter below net profit or loss after taxes for last five years:

Year	20___	20___	20___	20___	19___	19___
Amount	$_____	$_____	$_____	$_____	$_____	$_____

10. Individual who will sign or be responsible for submitting Self-Insurer's audited financial statements annually:
Name (Print): _____ Title: _____
Address: _____
Telephone No.: _____ Facsimile No.: _____

11. Applicant's current Hawaii health care contractor(s):
_____

12. Has an application for health care insurance ever been rejected or a policy cancelled?
Yes _____ No _____ If yes,
(a) On what date: _____
(b) Name of contractor: _____
(c) Reason for rejection/cancellation: _____

13. Individual in your organization who will be responsible for your self-insurance program:
Name (Print): _____ Title: _____
Address: _____
Telephone No.: _____ Facsimile No.: _____

14. Claim administration/functions (claims adjusting, etc.) will be performed by:

(a) If by self-insurer's own organization:
Name of administrator: _____ Title: _____
Address: _____
Telephone No.: _____ Facsimile No.: _____

(b) If by outside organization:
Name of organization: _____
Name of administrator: _____ Title: _____
Address: _____
Telephone No.: _____ Facsimile No.: _____

(c) Other _____

(d) Will the administrator have the authority to provide promptly all benefits due?
Yes _____ No _____
If no, explain limitations: _____
_____

15. Will the claims administration functions be performed at more than one location:
Yes _____ No _____
If yes, on a separate page provide all information requested in item 14 above for each adjusting location.

16. Will applicant's health care self-insurance program be supplemented by an insurance policy? Yes _____ No _____
If yes, attach a copy of the policy. (Any subsequent change in coverage should be filed with the Director.)

17. At the date of this application, is there any litigation or proceeding pending or threatened, the result of which might substantially adversely affect the financial condition, business or operations of the applicant or any of its subsidiaries? Yes _____ No _____
If yes, explain _____

_____

18. REQUIRED ATTACHMENTS:

(a) A current copy of the applicant's Independent Auditor's Report, complete with all schedules and notes, or upon written application, such other financial information as may be acceptable to the Director.

(b) If the report of the financial condition is dated more than twelve (12) months prior to the date of this application, the Director may require interim financial statements (Balance Sheet and Profit and Loss Statement) certified by the appropriate finance officers and dated not less than three (3) months from the date of this application.

(c) If a Corporation:

A copy of the resolution of the applicant corporation's Board of Directors authorizing the filing of an application for a certificate of consent to self-insurance and execution of the instrument of undertaking in furnishing security, if required.

(d) A copy of applicant's self-insured health care plan.

(e) A copy of the applicant's supplemental insurance policy per item 16.

19. The employer agrees to submit annually a copy of its independently audited financial statements within three (3) months following its year end to: State of Hawaii, Department of Labor and Industrial Relations, Disability Compensation Division, P.O. Box 3769, Honolulu, Hawaii 96812-3769.

Dated: _____

Signature: _____
Name (Print): _____
Title: _____
Telephone No.: _____
Facsimile No.: _____

Auxiliary aids and services are available upon request. Please call: (808) 586-9188; TTY (808) 586-8847; and for neighbor islands, TTY 1-888-569-6859. A request for reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected to discrimination, excluded from participation in, or denied the benefits of the department's services, programs, activities, or employment.